COMAR 31.10.12.06

Maryland Uniform Consultation Referral Form

Date of Referral:	Carrier Information:
Patient Information	Name:
Name: (Last, First, MI)	Address:
Date of Birth (MM/DD/YY) / Phone: ( )	Phone Number: ( )
Member #:	Facsimile/Data#: ( )
Site #:	

Primary or Requesting Provider:

Name: (Last, First, MI)	Specialty:	
Institution/Group Name:	Provider ID #:1	Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone Number: ( )	Facsimile/Data Number: ( )	

Consultant/Facility Provider:

Name: (Last, First, MI)	Specialty:	
Institution/Group Name:	Provider ID #:1	Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone Number: ( )	Facsimile/Data Number: ( )	

Referral Information

Reason for referral:

Brief History, Diagnosis, and Test Results:

Services Desired: Provide Care as Indicated

- ☐ Initial Consultation Only:
- ☐ Diagnostic Test (specify) _____
- ☐ Consultation with Specific Procedures: (specify) _____
- ☐ Specific Treatment _____
- ☐ Global OB Care & Delivery
- ☐ Other: (Explain) _____

Place of Service:

- ☐ Office
- ☐ Outpatient Medical/Surgical Center*
- ☐ Radiology ☐ Laboratory
- ☐ Inpatient Hospital*
- ☐ Extended Care Facility*
- ☐ Other: (Explain)

* (Specific Facility Must be Named)

Number of Visits: _____ If Blank, 1 Visit is Assumed	Authorization #: (If Required)	Referral is Valid Until: (Date) _____ (See Carrier Instructions)

Signature: (Individual Completing This Form)	**Authorizing Signature:** (If Required)

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.

White: Carrier; Yellow: Primary or Requesting Provider; Pink: Consultant/Facility Provider; Goldenrod: Patient

See Carrier/Plan Manual for Specific Instructions